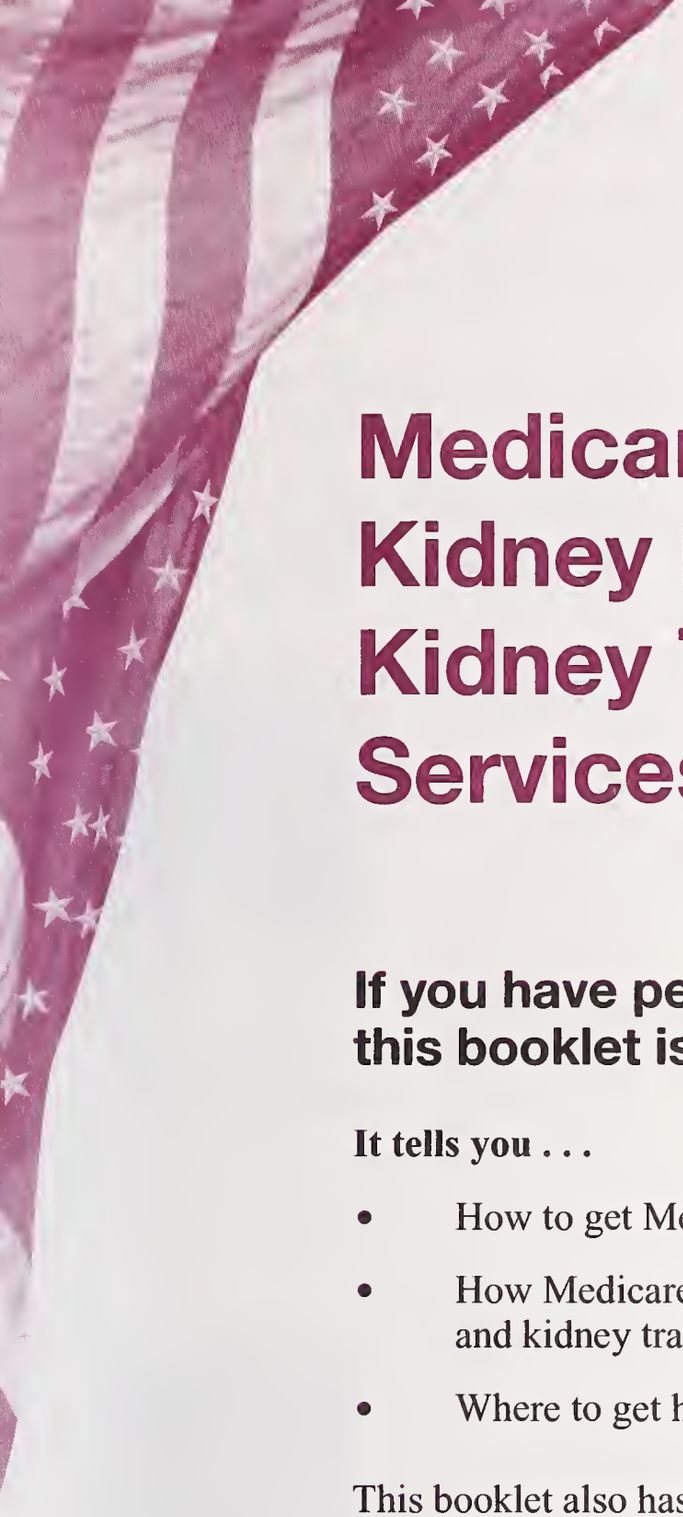


Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

If you have permanent kidney failure, this booklet is for you.

It tells you . . .

- How to get Medicare if your kidneys fail.
- How Medicare helps to pay for kidney dialysis and kidney transplants.
- Where to get help.

This booklet also has special information about pancreas transplants, see page 37.

To find out how to use this booklet, see page 5.

PUBS
RA
645
K5
M43
2000

HEALTH CARE FINANCING ADMINISTRATION
The Federal Medicare Agency

The Health Care Financing Administration would like to thank the American Association of Kidney Patients (AAKP) and its Executive Director, Kris Robinson, for providing the photos and quotes from AAKP members for this booklet. Thanks to the following AAKP members for sharing themselves and their experiences:

Bonny Willburn, Hemodialysis patient
Donald Dowe, MSW, Transplant patient
Rosalyn Feldman, Hemodialysis patient
Brenda Dyson, Transplant patient

RA
645
.K5
M43
2000

A Letter from Kidney Patients to Kidney Patients

Learning that you have permanent kidney failure is not easy. But we are here to tell you that even though you may feel sad, confused, or even frustrated, you can adjust and take control of your life. The fact that you're reading this booklet is a start.

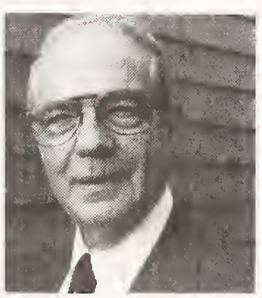
You may be worried about how to pay your medical costs. We know we were. But did you know that there is a program that will help pay your kidney dialysis and transplant costs, even if you're under age 65? That program is called Medicare, a federal health insurance program. That's what this booklet is about. You can read more about what Medicare is and how to sign up for it on page 10 of this booklet.

"I found out about Medicare coverage after a meeting with my social worker, who gave me all the information that was available."

- Bonny
Hemodialysis patient

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, MD 21244

"I had no knowledge of the relationship of ESRD and Medicare. I found out that Medicare covered dialysis from a co-worker. Thankfully, I followed that co-worker's advice."



- Don
Transplant
patient

"My End-Stage Renal Disease was sudden in 1987 and I did not know that Medicare was available to help cover the cost of dialysis treatments and other medical costs. When I learned that my disease made me eligible for Medicare, the burden of my hospital and medical costs were resolved."

- Rosalyn
Hemodialysis patient

Learning all of the "ins" and "outs" of Medicare can be confusing. If you have questions after reading this booklet, don't be afraid to ask someone for help. There are phone numbers of people that can help you on pages 50 and 51. You can also talk to the social worker at your dialysis facility or transplant center to get help understanding what is and isn't covered by Medicare.

Take care,

Bonny, Don, & Rosalyn
Kidney patients

Finding What You Want to Know

Introduction 4

How to Use This Booklet 5

Section 1: Medicare Basics

What is Medicare? 6
The Two Parts of Medicare 6-7
Medicare Health Plan Choices 7-8
Medicare for People With Kidney Failure 9-11
Who is Eligible? 9
How to Sign Up for Medicare 10-11
When Medicare Coverage Begins 12-13
When Medicare Coverage Ends 14
How Medicare Works With Employer Group Health Plan Coverage . . 15-17

Section 2: Kidney Dialysis

What is Dialysis? 18
Where to Get Dialysis Treatments 18
How to Find a Dialysis Facility 19
Home Dialysis Treatment Options 20
Knowing How Well Your Dialysis is Working 21
What is Covered by Medicare 22-23
What is Not Covered by Medicare 24
What YOU pay for Dialysis Services 25-31
Dialysis in a Dialysis Facility 25
Dialysis in a Hospital 26
Doctors' Services 26
Self-Dialysis Training 27
Home Dialysis 27-31
Dialysis When You Travel 31-32
Transportation to Dialysis Facilities 32

Section 3: Kidney Transplants

What is a Kidney Transplant? 33
Where to Get a Kidney Transplant 33
What is Covered by Medicare 34-37
Transplant Drugs (called Immunosuppressive Drugs) 35-36
Special Information About Pancreas Transplants 37
What YOU Pay for Kidney Transplant Services 37
Do I Have to Pay for My Kidney Donor? 37
Doctors' Services 38

Finding What You Want to Know

Section 4: How Medicare Pays for Blood

What YOU Pay for Blood 39
How to Have Blood Replaced 40

Section 5: Appeals and Grievances (Complaints)

Appeals
What to Do if Medicare Won't Pay for a Service That You Received 41
Filing a Grievance (Complaint)
What to Do if You Have Problems With the Services You Get 42

Section 6: Other Kinds of Health Insurance

Employee or Retiree Coverage From an Employer or Union 43
A Medigap Insurance Policy 43-44
Medicaid 45
Veteran Administration Benefits 46
Other Ways to Get Help 46

Section 7: Where to Get More Information

Special Kidney Organizations 47
End-Stage Renal Disease (ESRD) Networks 48
State Health Insurance Assistance Program (SHIP) 48
State Survey Agency 48
Other Medicare Booklets for Kidney Patients 49
ESRD Network and SHIP Phone Numbers 50-51

Section 8: Medicare Coverage Charts

Medicare Part A 52
Medicare Part B 53
Medicare Part B Preventive Services 54

Section 9: Definitions of Important Words

(Where terms in red are defined) 55-56

Section 10: Index

(An alphabetical list of topics in this booklet) 57-58

Introduction

This booklet explains how Medicare helps pay for kidney dialysis and kidney transplant services in the **Original Medicare Plan**, also known as "fee-for-service." If you are in a **Medicare managed care plan** or **Private Fee-for-Service plan**, your plan must give you at least the same coverage that the Original Medicare Plan gives, but it may have different rules. Your costs, rights, protections, and/or choices of where you get your care may be different if you are in one of these plans, and you may be able to get extra benefits. Read your plan materials or call your benefits administrator for more information.

This booklet does not have detailed information about kidney failure, dialysis treatments, and kidney transplants. To learn more about these things, talk with your health care team. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team. They are there to help you. You should also talk with your doctor about your treatment options. You and your doctor can decide what's best for you based on your situation.

"My kidney failure was very sudden. I had no time to prepare my mind or think about how I was going to pay for it. I was pleased to find out that I was eligible for Medicare. It took a great deal of stress away knowing that I had help paying for my illness."

- Brenda
Transplant
patient

Remember, terms in **red** are defined on pages 55-56.

How to Use This Booklet

This booklet has 10 sections. You can tell which section you are reading by the heading at the top of each page. Terms in red are defined on pages 55-56.

Do you:	**Read page(s) . . .**
Want to find a specific topic in this booklet?	57-58 - **Index:** An alphabetical list of all topics in this booklet and the page(s) where you will find the information you need.
Want to find out if you are eligible for Medicare?	9
Want to sign up for Medicare?	10 - 11
Want to know what Medicare covers for kidney dialysis?	22 - 23
Want to know what Medicare covers for kidney transplants?	34 - 37
Have an Employer Group Health Plan?	15 - 17
Want to know where to get help?	47 - 51
Have a problem or complaint?	41 - 42
Want to know about transportation to dialysis?	32
Want to know about dialysis when you travel?	31 - 32
Want to know what you pay for kidney dialysis?	25 - 31
Want to know what you pay for kidney transplants?	37 - 38
Want to know about transplant drugs?	35 - 36
Want to know other ways to get help with your health care costs?	43 - 46

Section 1: Medicare Basics

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older.
- Some people with disabilities under 65 years of age.
- People with **End-Stage Renal Disease** or ESRD (permanent kidney failure requiring dialysis or a transplant).

The Two Parts of Medicare

Medicare has two parts:

To get more details about what Medicare covers, look at the Medicare Part A and Part B coverage charts on pages 52-54.

1. **Part A (Hospital Insurance)** helps pay for:

   - Inpatient hospital care
   - Some skilled nursing facility care
   - Hospice care
   - Some home health care

   Most people get Part A automatically when they turn 65. They do not have to pay a monthly payment (**premium**) for Part A because they (or a spouse) paid Medicare taxes while they were working.

2. **Part B (Medical Insurance)** helps pay for:

   - Doctors' services
   - Outpatient hospital care
   - Some other medical services that Part A doesn't cover (like some home health care).

   Part B helps pay for these covered services and supplies when they are **medically necessary**.

(Continued on page 7.)

Remember, terms in **red** are defined on pages 55-56.

The Two Parts of Medicare (continued)

*The new Part B premium amount will be available by January 1, 2001.

2. **Part B (Medical Insurance), continued**

You pay the Medicare Part B **premium** of $45.50* per month in 2000. Rates can change yearly. In some cases, this amount may be higher if you did not choose Part B when you first became eligible at age 65. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not sign up for it. You will have to pay this extra 10% for the rest of your life. If you sign up for Medicare Part B based on **ESRD**, you may not have to pay this extra 10% for the rest of your life (see page 10).

Your Medicare Part B will stop if you do not pay the monthly premiums or if you decide to cancel it.

If you need Medicare because of kidney failure, see page 10 to find out how to sign up for it.

Medicare Health Plan Choices

Depending on where you live, you may have three choices:

1. **The Original Medicare Plan** (also known as fee-for-service),
2. A **Medicare managed care plan** (like an HMO), or
3. A **Private Fee-for-Service plan** (a new health care choice that will become available in some areas of the country in 2000).

(Continued on page 8.)

Medicare Health Plan Choices (continued)

If you've had a successful kidney transplant and are not on dialysis, you may be able to join a **Medicare managed care plan** or **Private Fee-for-Service plan**. If you start dialysis and are already in a Medicare managed care plan or Private Fee-for-Service plan, you can stay in your plan. **You must continue to pay the monthly Part B premium of $45.50* in 2000.**

*The new Part B premium amount will be available by January 1, 2001.

For more information about your Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the **"Medicare & You"** handbook. You can also read or print a copy of the this handbook at www.medicare.gov on the Internet. Click on "Publications."

Medicare does not pay for everything. There are some types of insurance that may pay some of the health care costs that Medicare doesn't pay (see pages 43-46).

Medicare for People with Kidney Failure

Who is Eligible?

You can get Medicare Part A no matter how old you are if your kidneys no longer work and you need regular dialysis or have had a kidney transplant, and:

- You have worked the required amount of time* under Social Security, the Railroad Retirement Board, or as a government employee; **or**
- You are getting or are eligible for Social Security or Railroad Retirement benefits; **or**
- You are the spouse or dependent child of a person who has worked the required amount of time* to be eligible for Medicare or who is getting Social Security or Railroad Retirement benefits.

If you get Medicare Part A you can also get Medicare Part B. Enrolling in Part B is your choice.

You will need both Part A and Part B in order for Medicare to cover certain dialysis and kidney transplant services.

If you can't get Medicare, you may be able to get help from your state to pay for your dialysis treatments (see page 45).

*Call the Social Security Administration at 1-800-772-1213 for more information about the required amount of time needed under Social Security to be eligible for Medicare. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Medicare for People with Kidney Failure

How to Sign Up for Medicare

- If you need Medicare only because of ESRD (permanent kidney failure), you can enroll in Medicare Part A and Part B based on ESRD at your local Social Security office. **Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.**

- If you have Medicare Part A because of age or disability and have not signed up for Part B, or if your Part B stopped, you may only sign up for Part B from January 1 through March 31 of each year (the General Enrollment Period). Part B coverage will be effective July 1 of the year you sign up.

The cost of Part B goes up 10% for each 12-month period you could have had Part B but did not sign up for it. **In order to keep from having to pay a higher Part B premium, you must enroll in Medicare Part A and Part B based on ESRD at your local Social Security office.** Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

If you are paying a higher Part B premium because you did not enroll in Part B when you were first eligible, you can pay the base premium rate of $45.50* per month in 2000 (see "Important Note" below).

*The new Part B premium amount will be available by January 1, 2001.

Important Note:
In order to stop paying the higher premium rate, you must enroll in Medicare based on ESRD. Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

Medicare for People with Kidney Failure

How to Sign Up for Medicare (continued)

"When I started dialysis, I already had Medicare because I was 67 years old. I had Medicare Parts A and B, but was paying a higher Part B premium because I didn't take it when I first got Medicare. My social worker told me to go to Social Security to enroll in Medicare based on ESRD. When I did that, the cost of my Part B premium went down."

-Linda
Transplant patient

Paying for Medicare Part B

When you sign up for Part B, the **premium** is usually taken out of your monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If you don't get any of these above payments, Medicare sends you a bill for your Part B premium every 3 months. You should get your Medicare premium bill by the 10th of the month. If you don't get your bill by the 10th, call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

Remember, you must pay your Medicare Part B premium. If you don't pay your Part B premium, or if you choose to cancel it, your Medicare Part B will end.

When Medicare Coverage Begins

When you first enroll in Medicare based on ESRD (permanent kidney failure) and you are on dialysis your Medicare coverage usually starts the fourth month of dialysis treatments. For example, if you start getting your hemodialysis treatments in July, your Medicare coverage would start on October 1.

If you are covered by an employer group health plan, your Medicare coverage will still start the fourth month of dialysis treatments. Your employer group health plan will pay first on your health care bills and Medicare will pay second for a 30-month **coordination period**. See pages 15-17, "How Medicare Works with Employer Group Health Plan Coverage."

If you don't have Employer Group Health Plan coverage, there are other types of insurance and programs that may help to pay some of your health care costs (see pages 43-46.)

There Are Three Ways You May Be Able to Get Medicare Coverage Sooner.

Important:
Medicare will not cover surgery or other services that are needed to prepare for dialysis (such as surgery for a blood access) if it is done before Medicare coverage begins.

1. **Medicare coverage can start as early as the first month of dialysis if . . .**

   - You take part in a home dialysis training program in a Medicare-approved training facility, to teach you how to give yourself dialysis treatments at home;
   - You begin home dialysis training before the third month of dialysis; and
   - You expect to finish home dialysis training and give yourself dialysis treatments.
     Talk to your doctor about your dialysis treatment options.

When Medicare Coverage Begins (continued)

2. **Medicare coverage can start the month you are admitted to a Medicare-approved hospital for a kidney transplant, or for health care services that you need before your transplant if . . .**

   - Your transplant takes place in that same month or within the two following months.

3. **Medicare coverage can start 2 months before the month of your transplant if . . .**

   - Your transplant is delayed more than 2 months after you are admitted to the hospital for the transplant or for health care services you need before your transplant (see Example, below).

Example:
Mrs. Perkins was admitted to the hospital on May 25th for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15th. However, her transplant was delayed until September 15th. Therefore, Mrs. Perkins' Medicare coverage will start in July, two months **before** the month of her transplant.

When Medicare Coverage Ends

If you have Medicare only because of kidney failure, your Medicare coverage will end:

- 12 months after the month you stop dialysis treatments, or
- 36 months after the month you had a successful kidney transplant.

Your Medicare coverage will not end if:

- You have to start dialysis again or get a kidney transplant within 12 months after the month you stopped getting dialysis, or
- You continue to get dialysis or get another kidney transplant within 36 months after a transplant.

Important:
Remember, in order for Medicare to pay for kidney dialysis and some transplant services, you need both Medicare Part A and Part B. If you don't pay your Medicare Part B **premium** or if you choose to cancel it, your Medicare Part B will end.

How Medicare Works With Employer Group Health Plan Coverage

If you are eligible for Medicare only because of permanent kidney failure, your Medicare coverage usually will not start until the fourth month of dialysis (see page 12). **Medicare will not pay anything during your first 3 months of dialysis unless you already have Medicare because of age or disability.** Therefore, your employer group health plan is the only payer for the first 3 months of dialysis.*

*If your employer plan does not pay all costs for dialysis, you may have to pay some of the costs. You may be able to get help to pay these costs (see pages 43-46).

When you are able to get Medicare because of kidney failure (usually the fourth month of dialysis), there is a period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. This period of time is called a 30-month **coordination period**. This means that if your employer plan doesn't pay 100% of your health care bills during the 30-month coordination period, Medicare may pay for the remaining costs. Medicare is called the **secondary payer** during this coordination period.

When the 30-Month Coordination Period Starts

The 30-month **coordination period** starts the first month you are able to get Medicare because of kidney failure (usually the fourth month of dialysis), even if you are not enrolled in Medicare yet. For example, if you start dialysis in June, the 30-month coordination period will start September 1, the fourth month of dialysis.

(Continued on page 16.)

Remember, terms in **red** are defined on pages 55-56.

How Medicare Works With Employer Group Health Plan Coverage

When the 30-Month Coordination Period Starts (continued)

If you take a course in self-dialysis training or get a kidney transplant during the 3-month waiting period, the 30-month **coordination period** will start with the first month of dialysis or kidney transplant. During this time, Medicare will be the **secondary payer**.

> **Important:**
> If you have employer group health plan coverage during the 30-month **coordination period**, tell the person who provides your medical care that you have an employer group health plan. This is very important in order to make sure that your services are billed correctly.

What Happens When the 30-Month Coordination Period Ends?

At the end of the 30-month **coordination period**, Medicare will pay first for all Medicare-covered services. Your employer group health plan coverage may pay for services not covered by Medicare. Check with your plan's benefits administrator.

How the 30-Month Coordination Period Works if You Enroll in Medicare More Than Once

There is a separate 30-month **coordination period** each time you enroll in Medicare based on kidney failure. For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end. If after 36 months you enroll in Medicare again because you start dialysis again or get another transplant, your Medicare coverage will start right away. There will be no 3-month waiting period before Medicare begins to pay. There will be a new 30-month coordination period if you have employer group health plan coverage.

How Medicare Works with Employer Group Health Plan Coverage

Do I Have to Get Medicare Because My Kidneys Fail, if I Already Have an Employer Group Health Plan?

No, but you should think carefully about this decision. If you already have an employer group health plan, consider the following:

1. If your group health plan coverage has a yearly **deductible** or a **coinsurance** to pay, enrolling in Medicare Parts A and B could help pay those costs.

2. If your group health plan coverage does not have a yearly deductible or a coinsurance and will pay all of your health care costs, you may want to delay enrolling in Medicare until the 30-month **coordination period** is over. Delaying in enrollment means that you will not be paying the Part B **premium**. After the 30-month coordination period, you should enroll in Medicare.

Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

For More Information About How Employer Group Health Plan Coverage Works With Medicare . . .

- Get a copy of your plan's benefits booklet, or
- Call your benefits administrator and ask how the plan pays when you have Medicare.

Remember, terms in **red** are defined on pages 55-56.

Section 2: Kidney Dialysis

What is Dialysis?

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure.

Where to Get Dialysis Treatments

Dialysis can be done at home or in a medical facility. In order for Medicare to pay for your treatments, the facility must be approved to provide dialysis (even if they already provide other Medicare-covered health care services).

At the dialysis facility, a nurse or a trained technician may give you the treatment. At home, you can treat yourself with the help of a family member or friend. If you decide to do home dialysis, you and your helper will get special training. (See page 20, "Home Dialysis Treatment Options").

Do you have a problem with the care that you're getting from your dialysis facility? If so, you have the right to file a **grievance** (complaint) to resolve your problem. See Section 5 on page 42, "Filing a Grievance (Complaint)" for more information.

Remember, terms in **red** are defined on pages 55-56.

How to Find a Dialysis Facility

In most cases, the facility your kidney doctor works with is where you will get dialysis treatments. However, you have the right to choose to get your treatments from another facility at any time. Keep in mind, this could mean changing doctors.

You can also call your local ESRD Network (see pages 50-51) to find a facility that is close to you.

Coming in November 2000 . . . "Dialysis Facility Compare," on the Internet

You will be able to get important information about Medicare-certified dialysis facilities in your area on the Internet at www.medicare.gov. Click on "Dialysis Facility Compare." This website will include information on where the dialysis facilities are located in your state, how big they are, and how long they have been in business.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

Home Dialysis Treatment Options

There are two types of dialysis that can be used at home, **hemodialysis** and **peritoneal dialysis**.

1. **Hemodialysis** uses a special filter (called a dialyzer) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the filter to clean out wastes and extra fluids. Then the newly cleaned blood flows through another set of tubes and back into your body. This treatment is also used for home dialysis.

2. **Peritoneal dialysis** uses a cleaning solution, called dialysate, that flows through a special tube into your abdomen. After a few hours, the dialysate gets drained from your abdomen, taking the wastes from your blood with it. Then you fill your abdomen with fresh dialysate and the cleaning process begins again.

How do I know what type of dialysis I need?

You should work with your doctor and your health care team to decide the type of dialysis you need. You and your doctor can decide what's best for you based on your situation. The goal is to help you stay healthy.

"I was 32 years old when I first found out that I had kidney failure. I had a college degree and planned on working, so I worked with my doctor and we chose home hemodialysis."

- Brenda
Transplant
patient

Knowing How Well Your Dialysis is Working

Most dialysis patients get hemodialysis. You can tell how well the hemodialysis is working by keeping track of your URR or Kt/V number. Blood test results can tell you your URR and Kt/V numbers. These numbers tell your doctor or nurse how well dialysis is removing wastes from your body. Your doctor or nurse usually keeps track of one or both of these numbers, depending on which test your dialysis facility uses. Check with your doctor or nurse to find out which test they use.

Medicare has more detailed information on knowing how well the hemodialysis is working in a brochure called **"Dialysis Keeps People with Kidney Failure Alive . . . Are You Getting Adequate Hemodialysis?"** This brochure also tells you what to do if you are not getting the right amount of dialysis. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of this brochure. You can also read or print a copy of this brochure at www.medicare.gov on the Internet. Click on "Publications."

Section 2: Kidney Dialysis

Dialysis Services and Supplies Covered by Medicare

Medicare covers these dialysis services and pays **part** of their costs:

Service or Supply	Medicare Part A	Medicare Part B
Inpatient dialysis treatments (if you are admitted to a hospital for special care)	✓	
Outpatient dialysis treatments (when you get treatments in any Medicare-approved dialysis facility)		✓
Self-dialysis training (includes instruction for you and for the person helping you with your home dialysis treatments)		✓
Home dialysis equipment and supplies (like alcohol, wipes, sterile drapes, rubber gloves, and scissors)		✓
Certain home support services (may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply)		✓
Certain drugs for home dialysis (see page 23)		✓
Outpatient doctors' services		✓
Most other services and supplies that are a part of dialysis, like laboratory tests		✓

To find out what **you** pay for these services, see pages 25-31.

Dialysis Services and Supplies Covered by Medicare

Home Dialysis Drugs Covered by Medicare

The most common drugs that Medicare Part B covers for home dialysis are:

- ✓ heparin,
- ✓ the antidote for heparin when medically necessary,
- ✓ topical anesthetics, and
- ✓ Epogen® or Epoetin alfa.

Talk with your doctor or any member of your health care team about the use of these and any other drugs.

Dialysis Services and Supplies NOT Covered by Medicare

Medicare does **not pay** for:

Service or Supply	Not covered
Paid dialysis aides to help with home dialysis	✗
Any lost pay to you and the person who may be helping you during self-dialysis training	✗
A place to stay during your treatment	✗
Blood or packed red blood cells for home self dialysis unless part of a doctors' service or is needed to prime the dialysis equipment	✗
Transportation to the dialysis facility (see page 32 for coverage in special cases)	✗

What YOU Pay for Dialysis Services

The costs listed in this section are for dialysis services in the **Original Medicare Plan**. If you are in a **Medicare managed care plan** or a **Private Fee-for-Service plan**, your costs may be different. Read your plan materials or call your benefits administrator to get information about your costs.

Dialysis in a Dialysis Facility

In the **Original Medicare Plan**, if you get dialysis in a Medicare-approved facility, Medicare Part B pays the facility for dialysis related services on a per treatment rate (called the composite rate). This rate may be different from one dialysis facility to another, depending on the type of facility and where it's located. Medicare pays 80% of the composite rate. You pay the remaining 20% **coinsurance** that Medicare does not pay. See Example below.

Example

Let's say the composite rate is $130 per treatment. After you pay the $100 Part B yearly deductible:

- Medicare Part B pays the facility 80% of $130 (or $104).
- You pay the remaining 20% **coinsurance** (or $26).

There may be other services that may not be included in the composite rate. Your dialysis facility can give you a list of tests and other services that are included in this rate. For services not included in the composite rate, Medicare pays 80% of the **Medicare-approved amount**. You must pay the 20% **coinsurance**.

(Continued on page 26.)

Remember, terms in **red** are defined on pages 55-56.

What YOU Pay for Dialysis Services

Dialysis in a Hospital

If you are admitted to a hospital and get dialysis, your treatments will be covered by Medicare Part A as part of the costs of your covered inpatient hospital stay. See the Medicare Part A coverage chart on page 52.

Doctors' Services

Outpatient Doctors' Services:

In the **Original Medicare Plan**, Medicare pays your kidney doctors once a month. The same monthly amount is paid for each patient the doctor cares for, whether dialysis is done in the home or in a dialysis facility. After you pay the $100 Part B yearly **deductible**, Medicare Part B pays 80% of the monthly amount. You pay the remaining 20% **coinsurance**. See Example below.

Example

Let's say the monthly amount that Medicare pays your doctor for each patient is $100. After you pay the $100 Part B yearly deductible:

- Medicare pays 80% of the $100 (or $80).
- You pay the remaining 20% **coinsurance** (or $20).

Inpatient Doctors' Services:

In the **Original Medicare Plan**, your kidney doctor can choose to be paid one of two ways for your inpatient hospital care:

1. Continue to get monthly payment (the same payment for outpatient doctors' services). In this case, you must pay 20% of the monthly amount for your doctor's services. You will not be billed for any extra costs.

2. Bill separately for inpatient services that are covered by Medicare Part A. In this case, your kidney doctor's monthly payment will be less based on the number of days you stay in the hospital. See the Medicare Part A coverage chart on page 52.

What YOU Pay for Dialysis Services

Self-Dialysis Training

Self-dialysis training is covered by Medicare Part B on an outpatient basis. Self-dialysis training costs more than dialysis treatments. The costs may be different from one dialysis facility to another, depending on the type of facility and where it's located. In the **Original Medicare Plan**, after you pay the $100 Part B yearly **deductible**, Medicare Part B will pay 80% of the training costs. You must pay the remaining 20% **coinsurance**. See Example below.

Example

Let's say the cost per training session is $150. After you pay the $100 Part B yearly deductible:

- Medicare Part B pays 80% of the $150 (or $120 per session).
- You must pay the remaining 20% coinsurance (or $30 per session).

Home Dialysis

You have two payment options for home dialysis:

1. **Dealing with Your Dialysis Facility (Method 1)**
   Under Method 1, you must get all services, equipment and supplies needed for home dialysis from your dialysis facility.

   In the **Original Medicare Plan**, the amount that Medicare pays the dialysis facility for these items and services depends on the composite rate, a rate that is set in advance. After you pay the $100 Part B yearly **deductible**, Medicare pays 80% of the composite rate. You pay the 20% **coinsurance**.

(Continued on page 28.)

Remember, terms in **red** are defined on pages 55-56.

What YOU Pay for Dialysis Services

Home Dialysis (continued)

2. **Dealing Directly With a Supplier (Method 2)** Under Method 2, you must get your dialysis equipment and supplies from one supplier. Your supplier must accept **assignment**.* This means that if you are in the **Original Medicare Plan**, your supplier agrees to accept Medicare's fee as full payment. Your supplier must also have a written agreement with a dialysis facility to make sure that you will get all necessary home dialysis support services. In the Original Medicare Plan, after you pay the $100 Part B yearly **deductible**, Medicare will pay 80% of the Medicare-approved charges for the items and services. You must pay the 20% **coinsurance**.

*For more information on how assignment works, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of **"Does your doctor or supplier accept assignment?"** You can also read or print a copy of this booklet at www.medicare.gov on the Internet.

Under both Method 1 and Method 2, you must get your support services from your dialysis facility in order for Medicare to pay. Medicare will pay the facility directly for these services.

The chart on page 29 has specific information on what you pay for home dialysis equipment, supplies, and support services in the **Original Medicare Plan** using the Method 1 and Method 2 payment options.

Method 1 and Method 2 Payment Chart for Home Dialysis Equipment, Supplies, and Support Services in the Original Medicare Plan

	Home Dialysis Equipment	Home Dialysis Supplies	Home Dialysis Support Services
Dealing With Your Dialysis Facility (Method 1)	Medicare pays 80% of the facility's composite rate. You pay the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. You pay the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. You pay the 20% coinsurance.*
Dealing Directly With a Supplier (Method 2)	If you buy or rent home dialysis equipment, Medicare Part B will cover it. You must pay the $100 Part B yearly deductible. Medicare Part B usually makes monthly payments. If you buy the equipment, Medicare will pay 80% of the monthly payment purchase price. You pay the 20% coinsurance. The monthly Part B payment includes any interest or carrying charges. If you rent the equipment, Medicare Part B pays 80% of the approved monthly rental charge. You pay the 20% coinsurance.	After you pay the $100 Part B yearly deductible, Medicare Part B pays 80% of the approved charges for all covered supplies. You pay the 20% coinsurance.	After you pay the $100 Part B yearly deductible, Medicare Part B pays the facility 80% of the approved charges for all covered services. You pay the 20% coinsurance.

*Each year, you pay a total of one $100 Part B deductible.

Remember, terms in red are defined on pages 55-56.

What YOU Pay for Dialysis Services

Deciding Which Payment Option to Choose For Home Dialysis

"I chose Method 2 because that's what my dialysis facility preferred."

- Brenda
Transplant
patient

Look at the Method 1 and Method 2 payment chart on page 29. It can help you decide which payment option is best for you if you are in the **Original Medicare Plan**. If you still have trouble deciding, ask your social worker to help you.

After you have finished self-dialysis training and are ready to make a choice, you must:

1. Fill out a Beneficiary Selection Form HCFA-382
2. Sign Form HCFA-382
3. Return Form HCFA-382 to your dialysis facility

You can get a copy of Form HCFA-382 from your dialysis facility. Once you make your choice and turn in the form, you must stay with that payment option until December 31 of that year. For example, if you decide to go with the Method 2 payment option in August 2000, you must stay with that option until December 31, 2000.

You can change from one method to the other by filling out a new Form HCFA-382 at any time, but the change will not start until the following January 1. For example, if you fill out your Form HCFA-382 to change to Method 1 and return it to your dialysis facility in October 2000, this change will not start until January 1, 2001.

Important:

No matter which method you choose, you can still make a change to get your treatment with a dialysis facility, or choose another facility.

What YOU Pay for Dialysis Services

How Long Will Medicare Pay For Home Dialysis Equipment?

Medicare Part B will pay for home dialysis equipment as long as you need dialysis at home. If you no longer need home dialysis, Part B will stop paying. For example, if you had a kidney transplant and no longer need home dialysis, then Part B would stop paying for your equipment.

If you buy your dialysis equipment, Part B payments will stop once the Medicare-approved purchase price is reached. For example, if Medicare agrees to pay $200 for your dialysis equipment, Part B payments will stop once Medicare pays $200.

Dialysis When You Travel

You need to make plans for your dialysis treatment along the route of your trip before your travel. Your dialysis facility will help you with these plans. Before you make your plans, think about the following:

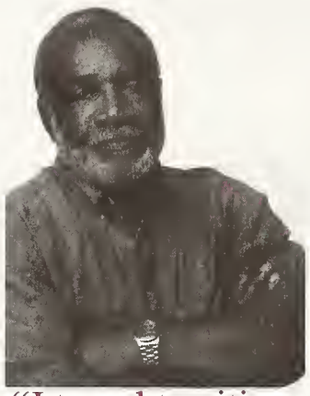
- ❒ Is the dialysis facility approved by Medicare to give dialysis?
- ❒ Does the facility have the space and time to give me care when I need it?
- ❒ Does the facility have enough information about me to give me the right treatment?
- ❒ Where is the facility located?

There are over 3,500 facilities around the country. Your facility or the ESRD Network (see pages 50-51) can help you get the names and addresses of those facilities.

(Continued on page 32.)

Starting in November 2000, you can also get information about Medicare-certified dialysis facilities in your area at www.medicare.gov on the Internet. Click on "Dialysis Facility Compare."

Dialysis When You Travel (continued)



"I travel to cities all over California for my job. The overnight trips are not a problem as long as I make plans for dialysis ahead of time in the cities I visit."

- Michael
Hemodialysis
patient

In general, Medicare will pay only for hospital or medical care that you get in the United States.

Caution:
Do you get your dialysis services from a Method 2 supplier (see page 28) or a Medicare managed care plan?

If so, your supplier or managed care plan may be able to help you get the dialysis you need while you travel. **You may have to pay all of the costs for your dialysis treatments**. Contact your supplier or health plan for more information.

Transportation to Dialysis Facilities

Does Medicare Pay for Transportation to Dialysis Facilities?

In most cases, no. Medicare covers roundtrip ambulance services from home to the nearest dialysis facility **only** if other forms of transportation would be harmful to your health.

The ambulance supplier must get a written order from your main doctor before you get the ambulance service. The doctor's written order must be dated no earlier than 60 days before you get the ambulance service.

For more information about ambulance coverage, call the Social Security Administration at 1-800-772-1213.

Section 3: Kidney Transplants

What is a Kidney Transplant?

A kidney transplant is a type of surgery that is done to put a healthy kidney from another person into your body. This new kidney does the work that your own kidneys can't do. You may get a kidney from someone who has recently died or from someone who is still living, like a family member. The blood and tissue of the person who gives you the kidney must be tested. This is done to see how well they match yours so that your body won't reject the new kidney.

Where to Get a Kidney Transplant

Your kidney transplant must be done in a hospital that is approved by Medicare to do kidney transplants.

Do you have a problem with the care that you're getting for your transplant? If so, you have the right to file a **grievance** (complaint) to resolve your problem. See page 42, "Filing a Grievance (Complaint)," for more information.

Remember, terms in **red** are defined on pages 55-56.

Section 3: Kidney Transplants

Kidney Transplant Services Covered by Medicare

Medicare covers these transplant services and pays **part** of their costs:

Service or Supply	Medicare Part A	Medicare Part B
Inpatient hospital services in an approved hospital (see the Medicare Parts A and B coverage charts on pages 52-54)	✓	
Kidney Registry Fee	✓	
Laboratory and other tests needed to evaluate your medical condition*	✓	
Laboratory and other tests needed to evaluate the medical conditions of potential kidney donors*	✓	
The costs of finding the proper kidney for your transplant surgery (if there is no kidney donor)	✓	
The full cost of care for your kidney donor (including all reasonable preparatory, operation, and postoperative recovery costs)	✓	
Any additional inpatient hospital care for your donor in case of problems due to the surgery	✓	
Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery)		✓
Doctor's services for your kidney donor during their hospital stay		✓
Immunosuppressive drugs (for a limited time after you leave the hospital following a transplant, see page 35)		✓
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood, see page 39)	✓	✓

*These services are covered whether they are done by the Medicare-approved hospital where you will get your transplant, or by another hospital that participates in Medicare.

Section 3: Kidney Transplants

Transplant Services Covered by Medicare

To find out what you pay for the services in the chart on page 34, see pages 37-38.

Note: Medicare does not pay for the actual kidneys for a transplant. Buying or selling human organs is against the law.

Transplant Drugs (called Immunosuppressive Drugs)

What are Immunosuppressive Drugs?

Immunosuppressive drugs are transplant drugs used to reduce the risk of your body rejecting your new kidney after your transplant. You will need to take these drugs for the rest of your life.

What if I Stop Taking My Transplant Drugs?

If you stop taking them, your body may reject your new kidney and the kidney could stop working. If that happens, you will have to start dialysis again.

How Long Will Medicare Pay for Transplant Drugs?

If you have Medicare only because of kidney failure, Medicare will pay for your immunosuppressive drug therapy for 36 months after the month of the transplant.

If you already had Medicare because of age or disability before you got **ESRD**, or if you became eligible for Medicare because of age or disability after receiving a transplant, you may be covered longer for immunosuppressive drugs. Starting January 1, 2000, if your 36-month period of drug coverage ends during the calendar year 2000, Medicare will pay for an extra 8 months of immunosuppressive drugs beyond the current 36-month period (see example on page 36). If your 36-month period ends during any of the next four calendar years (from the year 2001 to 2004), Medicare may extend your drug coverage more or less than eight months.

If you have Medicare only because of kidney failure, this does not apply to you. Your Medicare and drug coverage will end when your 36-month period is up.

(Continued on page 36.)

Transplant Services Covered by Medicare

How Long Will Medicare Pay for Transplant Drugs? (continued)

Example:
Mr. Smith already had Medicare because of a disability when he got permanent kidney failure. He got a kidney transplant in October 1997. His 36-month period for Medicare coverage of immunosuppressive drug therapy ends in October 2000. Because he already had Medicare because of disability and his 36-month period ends during the calendar year 2000, he will get an extra 8 months of drug coverage beyond October 2000. This means that Mr. Smith will be covered by Medicare for immunosuppressive drugs through June 2001.

What if I Can't Pay for the Transplant Drugs?

Transplant drugs can be very costly and Medicare only pays for them for a certain period of time. If you are worried about paying for them, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs. (See pages 43-46 to learn more about other health insurance.)

Transplant Services Covered by Medicare

Special Information About Pancreas Transplants

If you have ESRD and need a pancreas transplant, Medicare covers pancreas transplants:

- When it is done at the same time you get a kidney transplant, **or**
- After a kidney transplant.

If you have the pancreas transplant after the kidney transplant, Medicare will pay for your immunosuppresive drug therapy for 36 months after the month of the pancreas transplant.

If you have diabetes and do not have kidney failure due to diabetes, this coverage does not apply to you.

What YOU Pay for Kidney Transplant Services

The amounts listed in this section are for transplant services in the **Original Medicare Plan**. If you are in a **Medicare managed care plan** or a **Private Fee-for-Service plan**, your costs may be different. Read your plan materials or call your benefits administrator to get information about your costs.

Do I Have to Pay for My Kidney Donor?

No. Medicare will pay the full cost of care for your kidney donor. There is no **deductible**, **coinsurance**, or other costs that you have to pay for your donor's hospital stay.

(Continued on page 38.)

Remember, terms in **red** are defined on pages 55-56.

What YOU Pay for Kidney Transplant Services

Doctors' Services

In the **Original Medicare Plan**, you must pay the $100 Part B yearly **deductible**. After you pay the deductible, Medicare Part B pays 80% of the **Medicare-approved amount**. You must pay the remaining 20% **coinsurance**.

Important:
There is a limit on the amount your doctor can charge you, even if your doctor doesn't accept **assignment**. If your doctor doesn't accept assignment, you only have to pay the part of the bill that is over the **Medicare-approved amount** up to the limit that Medicare allows your doctor to charge. Call 1-800-MEDICARE (1-800-633-4227) to get a free copy of **"Does your doctor or supplier accept assignment?"** This booklet will give you detailed information on how assignment works.

Note: See the chart on page 52 for details about what you pay under Medicare Part A.

— Section 4: How Medicare Pays for Blood —

In most cases, Medicare Part A and B can help pay for:

- ✓ whole blood units or packed red blood cells,
- ✓ blood components, and
- ✓ the cost of processing and giving you blood.

Medicare does not pay for blood for home self-dialysis unless it's part of a doctor's service or is needed to prime the dialysis equipment.

What YOU Pay for Blood

Under **Medicare Part A**, you pay for:

The first three units of whole blood or units of packed red cells that you get during a **benefit period** while you are staying in a hospital or skilled nursing facility. You can choose to either pay the hospital costs for the blood or packed red cells or you can have the blood replaced (see "How to Have Blood Replaced," on page 40).

Note: If you have paid for or replaced some units of blood under Medicare Part B during the calendar year (January 1 through December 31), you don't have to do so again under Medicare Part A.

Under **Medicare Part B**, you pay for:

The first three units of whole blood or units of packed red cells that you get in a calendar year. You can choose to either pay the hospital costs for the blood or packed red cells or you can have the blood replaced (see "How to Have Blood Replaced," on page 40).

In the **Original Medicare Plan**, Medicare Part B pays 80% of the approved charges for extra pints of blood in a calendar year. You pay the remaining 20% **coinsurance**.

Remember, terms in **red** are defined on pages 55-56.

(Continued on page 40.)

What YOU Pay for Blood (continued)

> **Note:** If you have paid for or replaced blood under Medicare Part A during a calendar year (January 1 through December 31), you don't have to do so again under Medicare Part B.

How to Have Blood Replaced

You can replace the blood yourself by donating blood, or getting another person or organization to replace the blood for you. The blood that is replaced does not have to match your blood type. If you decide to replace the blood yourself, check with your doctor first before donating blood.

Can I Be Charged for the Blood That I Have Replaced?

No. A hospital or skilled nursing facility can't charge you for any of the first three pints of blood you have already replaced or will have replaced. Also, if your provider receives donated blood or red cells, the blood or red cells is considered to be replaced.

Appeals

What to Do if Medicare Won't Pay for a Service You Received

If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can file an **appeal** (question it). This is true whether you are in the **Original Medicare Plan**, a **Medicare managed care plan**, or a **Private Fee-for-Service plan**.

Appeal Rights in The Original Medicare Plan

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

Appeal Rights in a Medicare managed care plan or Private Fee-for-Service plan

If you are in a Medicare managed care plan or a Private Fee-for-Service plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. You may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about your rights during an appeal.

Remember, terms in **red** are defined on pages 55-56.

Filing a Grievance (Complaint)

What to Do if You Have Problems With the Services You Get?

- Talk with your doctor, nurse, or facility administrator first to see if they can help you solve your problem. Most problems can be handled at your facility.
- If talking to your health care team does not solve the problem, you can file a **grievance** (a written complaint) with your facility.

Every facility has a grievance policy for accepting and trying to work out your problems or concerns. If you don't know your facility's grievance policy, you can ask for a copy of it.

If you file a grievance with your facility and you still feel that your problem has not been solved, you have the right to file a grievance with the ESRD Network in your area. Call the ESRD Network to find out what you have to do in order to file a grievance (see pages 50-51).

You can also call your State Survey Agency to complain about your care. **Your calls and who you are will be kept private.** Call 1-800-MEDICARE (1-800-633-4227) and ask for the number to your State Survey Agency, or look at www.medicare.gov on the Internet and click on "Helpful Contacts."

Remember, terms in **red** are defined on pages 55-56.

Other Kinds of Health Insurance

There are several kinds of health insurance coverage that may help pay for the services you need for the treatment of kidney failure. They include:

1. Employee or Retiree Coverage From an Employer or Union (see below)
2. A Medigap Insurance Policy (see below)
3. Medicaid (see page 45)
4. Veteran Administration Benefits (see page 46)

1. Employee or Retiree Coverage From an Employer or Union

This type of group health coverage is for current employees or retirees. Generally, employer plans have better rates than you can get if you buy a policy yourself, and employers pay part of the cost. Call your benefits administrator to find out if you have or can get health care coverage based on your or your spouse's past or current employment, or your parents' current employment.

In some cases, employer group health plans will have to pay before Medicare pays (see page 15).

2. A Medigap Insurance Policy

A "Medigap" insurance policy fills gaps in **Original Medicare Plan** coverage. Medigap insurance must follow federal and state laws. These laws protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

(Continued on page 44.)

Remember, terms in **red** are defined on pages 55-56.

2. A Medigap Insurance Policy (continued)

Some insurance companies will sell Medigap policies to people with Medicare under age 65. However, these policies may cost you more. Call your State Health Insurance Assistance Program for information about buying a Medigap policy if you are disabled or have **ESRD** (see pages 50-51).

For more detailed information about Medigap policies:

✓ Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the **"Guide to Health Insurance for People with Medicare."**

✓ Visit www.medicare.gov on the Internet to get information on Medigap policies in your state. Click on "Medigap Compare." This website has information on:

- Which Medigap policies are sold in your state.
- Shopping for a Medigap policy.
- What these policies must cover.
- How insurance companies decide what to charge you for a Medigap policy premium.
- Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

3. Medicaid

This is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid.

States also have programs that pay some or all of Medicare's **premiums** and may also pay Medicare **deductibles** and **coinsurances** for certain people who have Medicare and a low income. To qualify for these programs, you must:

- Have Medicare Part A (hospital insurance). If you're not sure if you have Part A, look on your red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.

- Have a monthly income of less than $1,238 for an individual or $1,661 for a couple in 2000. These income limits are slightly higher in Hawaii and Alaska.

- Have savings $4,000 or less for an individual or $6,000 for a couple. Savings include money in a checking or savings account, stocks, or bonds.

To get more information on these programs, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for information on **"Savings for Medicare Beneficiaries."**

Remember, terms in **red** are defined on pages 55-56.

4. Veteran Administration Benefits

If you are a veteran, the U.S Department of Veteran Affairs can help pay for **ESRD** treatment. For more information, call the U.S. Department of Veteran Affairs at 1-800-827-1000. If you or your spouse are retired from the military, call the Department of Defense at 1-800-538-9552 for more information.

"When my kidneys failed, I had employer group health insurance along with Medicare. When I lost my job, I was able to get medical care from the Veteran's Administration."

- Don
Transplant
patient

Other Ways to Get Help

- In most states there are agencies that help with some of the health care costs that Medicare doesn't pay.
- Some states have Kidney Commissions that also help people pay the costs that Medicare doesn't pay.
- Call your State Health Insurance Assistance Program if you have questions about health insurance (see pages 50-51).

—Section 7: Where to Get More Information –

Talk with your health care team to learn more about kidney dialysis and transplants and your situation. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team.

Special Kidney Organizations

There are special organizations that can give you more information about kidney dialysis and kidney transplants. Some of these organizations have members who are on dialysis or have had kidney transplants who can give you support.

American Association of Kidney Patients
100 S. Ashley Dr. Suite 280
Tampa, Florida 33602
1-800-749-2257
www.aakp.org (on the Internet)

American Kidney Fund
6110 Executive Blvd, Suite 1010
Rockville, MD 20852-3903
1-800-638-8299
www.akfinc.org (on the Internet)

National Kidney Foundation, Inc.
30 E. 33rd Street, 11th Floor
New York, NY 10016
1-800-622-9010
www.kidney.org (on the Internet)

National Kidney and Urologic Diseases Information Clearinghouse
3 Information Way
Bethesda, Maryland 20892
301-654-4415
www.niddk.nih.gov (on the Internet)

- Section 7: Where to Get More Information -

End-Stage Renal Disease (ESRD) Networks

You can call your local ESRD Network Organization (see pages 50-51) to get information about:

- Dialysis or kidney transplants.
- How to get help from other kidney-related agencies.
- Problems with your facility that are not solved after talking to the staff at the facility.
- Location of dialysis facilities and transplant centers.

Your ESRD Network makes sure that you are getting the best possible care, and uses mailings to keep your facility aware of important issues about kidney dialysis and transplants.

State Health Insurance Assistance Program (SHIP)

Call your State Health Insurance Assistance Program (see pages 50-51) if you have questions about:

- Medigap Policies.
- Medicare health plan choices.
- Help with filing an appeal.
- Other general health insurance questions.

State Survey Agency

The State Survey Agency inspects dialysis facilities and makes sure that Medicare standards are met. Your State Survey Agency can also help you if you have a complaint about your care. Call 1-800-MEDICARE (1-800-633-4227) and ask for the number to your State Survey Agency, or look at www.medicare.gov on the Internet and click on "Helpful Contacts." **Your calls and who you are will be kept private**.

- Section 7: Where to Get More Information -

Other Medicare Booklets for Kidney Patients

Medicare has two booklets:

1. **"Dialysis keeps people with kidney failure alive . . . Are You Getting Adequate Hemodialysis?"**

   This booklet tells you how to check on how well your dialysis is working. It also tells you what to do if you're not getting the right amount of dialysis.

2. **"Preparing for Emergencies, A Guide for People on Dialysis."**

   This guide gives you important facts about what to do in case of an emergency that leaves you without power or water. It guides you through the information you should have ready, provides lists of supplies to have on hand to prepare for emergencies, and gives helpful ideas on how to manage until conditions return to normal.

To get your free copy of these booklets, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired). You can also look at or print a copy of these booklets at www.medicare.gov on the Internet. Click on "Publications."

Important Phone Numbers

ESRD Networks and State Health Insurance Assistance Program phone numbers are on pages 50-51. At the time of printing, these phone numbers were correct. Phone numbers sometimes change. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or look on the Internet at www.medicare.gov and click on "Helpful Contacts."

State	ESRD Networks	SHIP
Alabama	(877) 936-9260	(334) 242-5743
Alaska	(206) 923-0714	(907) 269-3680
American Samoa	(415) 472-8590	(808) 586-7299
Arizona	(800) 783-8818	(800) 432-4040
Arkansas	(800) 472-8664	(800) 224-6330
California	(800) 637-4767	(800) 434-0222
Colorado	(800) 783-8818	(888) 696-7213
Connecticut	(203) 387-9332	(860) 424-5245
Delaware	(800) 548-9205	(302) 739-6266
Florida	(813) 251-8686	(850) 414-2060
Georgia	(919) 788-8112	(404) 657-5334
Guam	(415) 472-8590	(808) 586-7299
Hawaii	(415) 472-8590	(808) 586-7299
Idaho	(206) 923-0714	(208) 334-4350
Illinois	(800) 456-6919	(217) 785-9021
Indiana	(800) 456-6919	(800) 452-4800
Iowa	(816) 880-9990	(800) 351-4664
Kansas	(816) 880-9990	(316) 337-7386
Kentucky	(800) 456-6919	(502) 564-7372
Louisiana	(800) 472-8664	(225) 342-5301
Maine	(203) 387-9332	(207) 623-1797
Maryland	(804) 794-3757	(410) 767-1100
Massachusetts	(203) 387-9332	(617) 727-7750
Michigan	(800) 973-3773	(800) 803-7174
Minnesota	(800) 973-3773	(800) 333-2433
Mississippi	(877) 936-9260	(800) 948-3090
Missouri	(816) 880-9990	(800) 390-3330
Montana	(206) 923-0714	(406) 444-7781

State	ESRD Networks	SHIP
Nebraska	(816) 880-9990	(800) 234-7119
Nevada	(800) 783-8818	(702) 486-3478
New Hampshire	(203) 387-9332	(603) 225-9000
New Jersey	(609) 395-5544	(609) 588-3139
New Mexico	(800) 783-8818	(505) 827-7640
New York	(212) 289-4524	(800) 333-4114
North Carolina	(919) 788-8112	(919) 733-0111
North Dakota	(800) 973-3773	(701) 328-2440
Ohio	(800) 456-6919	(614) 644-3458
Oklahoma	(800) 472-8664	(405) 521-6628
Oregon	(206) 923-0714	(503) 947-7984
Pennsylvania	(800) 548-9205	(800) 783-7067
Puerto Rico	(609) 395-5544	(787) 721-8590
Rhode Island	(203) 387-9332	(401) 222-2880
South Carolina	(919) 788-8112	(803) 898-2850
South Dakota	(800) 973-3773	(605) 773-3656
Tennessee	(877) 936-9260	(800) 525-2816
Texas	(972) 503-3215	(800) 252-9240
Utah	(800) 783-8818	(801) 538-3910
Vermont	(203) 387-9332	(802) 748-5182
Virgin Islands	(609) 395-5544	(340) 778-6311x2338
Virginia	(804) 794-3757	(800) 552-3402
Washington	(206) 923-0714	(800) 397-4422
Washington D.C.	(804) 794-3757	(202) 739-0668
West Virginia	(804) 794-3757	(877) 987-4463
Wisconsin	(800) 973-3773	(877) 333-0202
Wyoming	(800) 783-8818	(800) 856-4398

- Section 8: Medicare Part A Coverage Chart -

Medicare Part A (Hospital Insurance) Helps Pay For:	What YOU Pay in 2000* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless **medically necessary**. Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period YOU pay:** • A total of $776 for a hospital stay of 1-60 days. • $194 per day for days 61-90 of a hospital stay. • $388 per day for days 91-150 of a hospital stay. • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: ** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay). To get a free booklet about SNF care, call 1-800-MEDICARE (1-800-633-4227).	**For each benefit period YOU pay:** • Nothing for the first 20 days. • Up to $97 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary.
Home Health Care: ** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services. To get a free booklet about home health care, call 1-800-MEDICARE (1-800-633-4227).	**YOU pay:** • Nothing for home health care services. • 20% of the **Medicare-approved amount** for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.
Hospice Care: ** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered. To get a free booklet about hospice care, call 1-800-MEDICARE (1-800-633-4227).	**YOU pay:** • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	**YOU pay:** For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2001.

** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary. Call 1-800-MEDICARE (1-800-633-4227) and ask for the phone number for your Fiscal Intermediary.

- Section 8: Medicare Part B Coverage Chart -

Medicare Part B (Medical Insurance) Helps Pay For:	What YOU Pay in 2000* in the Original Medicare Plan (see Note below)
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions. To get a free booklet about second surgical opinions, call 1-800-MEDICARE (1-800-633-4227).	**YOU pay:** • $100 **deductible** (pay once per calendar year). • 20% of **Medicare-approved amount** after the deductible, except in the outpatient setting.
Also covers outpatient physical and occupational therapy including speech-language therapy.	• 20% for all outpatient physical, occupational, and speech-language therapy services.
Outpatient mental health care.	• 50% for outpatient mental health care.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**YOU pay:** • Nothing for Medicare-approved services.
Home Health Care: ** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.	**YOU pay:** • Nothing for Medicare-approved services. • 20% of Medicare-approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury. To get a free booklet about payment for outpatient hospital services, call 1-800-MEDICARE (1-800-633-4227).	**YOU pay:** • A **coinsurance** or fixed copayment amount which may vary according to the service.
Blood: Pints of blood you get as an outpatient, or as part of a Part B covered service.	**YOU pay:** For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the **deductible**), unless you or someone else donates blood to replace what you use.

* New Part A and B amounts will be available by January 1, 2001.
** You must meet certain conditions in order for Medicare to cover these services or equipment.

Note: Actual amounts you must pay are higher if the doctor or supplier does not accept **assignment**, and you may have to pay the entire cost. Medicare will then send you its share of the costs. If you have general questions about Medicare Part B, call your Medicare Carrier. If you have questions about durable medical equipment, including diabetic supplies, call your DMERC.

Section 8: Medicare Part B Preventive Services

Medicare Part B Covered Preventive Services	Who is covered...	What YOU pay in the Original Medicare Plan...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the **Medicare-approved amount** (or a set copayment amount) after the yearly Part B **deductible**.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every 12 months. • Flexible Sigmoidoscopy* - Once every 48 months. • Colonoscopy* - Once every 24 months if you are at high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. (*25% if performed in an ambulatory surgical center or hospital outpatient department.)
Diabetes Services: • Coverage for glucose monitors, test strips, and lancets.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the yearly Part B deductible.
• Diabetes self-management training.	If requested by your doctor or other provider.	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.)	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months.	All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No **coinsurance** and no Part B deductible for the PSA Test.
Shots (vaccinations): • Flu Shot - Once a year in the fall or winter. • Pneumonia Shot - One shot may be all you ever need. Ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	Nothing for flu and pneumonia shots if the health care provider accepts **assignment**. For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.

- Section 9: Definitions of Important Words -

Appeal
An appeal is a special kind of complaint you make if you disagree with any decision about your health care service. For example, if Medicare doesn't pay for a service you got. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint.

Assignment
In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. **You still pay your share of the cost of the doctor visit.**

Benefit Period
The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance
The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Coordination Period
A period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.

Deductible
The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

End-Stage Renal Disease (ESRD)
Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

General Enrollment Period (GEP)
The GEP is January 1 through March 31 of each year. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1.

Grievance
A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see **Appeal**).

- Section 9: Definitions of Important Words -

Medicare-Approved Amount
The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medically Necessary
Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good medical practice in the medical community of your local area; and
- are not mainly for the convenience of you or your doctor.

Medicare Managed Care Plans
These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Original Medicare Plan
A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance).

Premium
What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Private Fee-for-Service Plan
A new health care choice in some areas of the country. It is a Medicare health plan offered by a private insurance company. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Secondary Payer
The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Section 10: Index

American Association of Kidney Patients 47
American Kidney Fund 47
Appeals 41, 55
Assignment 28, 38, 55
Benefit Period 52, 55
Blood Coverage 39-40
Coinsurance 25-27, 29, 38, 53-55
Deductible 26-27, 29, 38, 53-55
Definitions of Important Words 55-56
Dialysis 18-32
- Finding a dialysis facility 19
- Transportation 32
- Travel 31-32
- What you pay 25-31
- What's covered 22-23
- What's not covered 24

Employer Group Health Plan 15-17, 43
Enrollment (Medicare) 10
ESRD Networks 48, 50, 51
General Enrollment Period 10
Grievance 42, 55
Home Self-Dialysis 27-31
Immunosuppressive Drugs 35-36
Kidney Organizations 47
Kidney Transplant 33-38
- Drugs 35-36
- What you pay 37-38
- What's covered 34-37

Section 10: Index

Medicaid 45
Medicare Coverage (Begins) 12-13
Medicare Coverage (Ends) 14
Medicare managed care plans 7-8, 56
Medigap Insurance 43-44
National Kidney Foundation, Inc. 47
National Kidney and Urologic Diseases Information Clearinghouse 47
Original Medicare Plan 7-8, 56
Pancreas Transplant 37
Part A (Hospital Insurance) 6, 9
Part B (Medical Insurance) 6, 9-11
Phone numbers for help 50-51
Premium 6-7, 10
Private Fee-for-Service plan 7-8, 56
Secondary Payer 15, 56
Self-Dialysis Training 27
State Health Insurance Assistance Program 48, 50-51
Transportation to dialysis 32
Travel (Dialysis) 31-32
Veteran Administration Benefits 46

Important Phone Numbers

Phone Number

Doctor

_____ ___-___-____

Social Worker

_____ ___-___-____

Dialysis Facility

_____ ___-___-____

Health Insurance Company

_____ ___-___-____

ESRD Network

_____ ___-___-____

State Survey Agency

_____ ___-___-____

_____ ___-___-____

_____ ___-___-____

_____ ___-___-____

Notes

Notes

CMS Library
C2-07-13
7500 Security Blvd
Baltimore, MD 21244

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS LIBRARY
3 8095 00008966 0

Official Business
Penalty for Private Use, $300

Publication No. HCFA - 10128
August 2000

Please Note: If you did not get an information update sheet with this booklet, call 1-800-MEDICARE(1-800-633-4227, or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for one.

This publication will be available in Spanish by November 2000. To get your copy, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

Esta publicación estará disponible en Español en noviembre 2000. Para dotener su copia, llame al 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 para personas con impedimento auditivos o de lenguaje oral).

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration